

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

19839

6091

ED JUL 13 1943 318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

## 1. PLACE OF DEATH:

- (a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1617a Cass Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Frances Marozewski

3. (b) If veteran, name war - 3. (c) Social Security No. -

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased March 3 1885  
(Month) (Day) (Year)

8. AGE: Years 58 Months 3 Days 29 If less than one day  
hr. min.

9. Birthplace Warsaw Poland  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

- MOTHER FATHER { 12. Name ? Dudkiewicz  
13. Birthplace Poland  
(City, town, or county) (State or foreign country)  
14. Maiden name Poland  
15. Birthplace Poland  
(City, town, or county) (State or foreign country)

16. (a) Informant Helen Bukowski  
(b) Address 1617a Cass Ave

17. (a) Burial (b) Date thereof 7/5/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery18. (a) Signature of funeral director General Funeral Home Inc.  
(b) JUL 4 1943 University St.

19. (a) (Date received local registrar) (b) J. F. [Signature]  
(Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1617a Cass Ave.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2  
year 1943 hour 10 minute 28 P. M.

21. I hereby certify that I attended the deceased from March 9, 1943 to death, July 2, 1943  
that I last saw her alive on July 1, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy (Cerebral hemorrhage) Duration 3 days

Due to 1/2/1Due to Cardiac diseaseOther conditions Cardiac disease  
(Include pregnancy within 3 months of death)Major findings:  
Of operations

Of autopsy

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?.....  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature Edwin Sauter M.D. (M. D. or other)  
Address 5189 Enright Dr. Date signed 7-3-43

Dr. E. Sauter  
5189 Enright  
Po. 1872

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed.....

*Van M. Sauter*

Licensed Embalmer No. ....

*4343*

P. O. Address.....

*Maplewood, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**